

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

16130

Reg. Dist. No. 166

1. PLACE OF DEATH: Garrett  
County: Garrett  
City or town: Mt. Lake Park  
(If outside city or town limits, write RURAL and give nearest town) 18 Mo.  
How long in above place of death?  
Hospital, Institution, or street address where death occurred: Kiser's Nursing Home  
Street No.: 18 Mo.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State: Maryland County: Allegheny  
City or town: Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.:  
(If rural, give LOCATION)  
2.(a) If veteran, name war:

3. (a) FULL NAME  
Charles Clark Adams

3. (b) Social Security Number  
215-05-2204

4. Sex: Male Color or race: White 5. (a) Single, married, widowed, or divorced: Single

6. (b) Name of husband or wife: ---  
6. (c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.) February 10, 1877

8. AGE: Years: 68 Months: 7 Days: 25 If less than one day: hrs: min:

9. Birthplace: Allegheny Co., Md. (Town, county, and state)

10. Usual occupation: Blacksmith and Machinist

11. Industry or business: Coal mines

12. Name: James W. Adams

13. Birthplace: Clear Spring, Md.

14. Maiden name: Geneva McCune

15. Birthplace: Allegheny Co., Pa.

16. Informant: Harold Adams

Address: Vindex, Md.

17. Burial: Date thereof: October 7, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: Herbert P. Leighton

Address: Oakland, Md.

19. Date rec'd by registrar: 10/6/45 Date signed: 45 Julia Rawson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5, 1945 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-14-45 to 19-10-45 and that I last saw him alive on 19-10-45.

Immediate cause of death: Dilated heart and Atherosclerosis DURATION 16 yrs

Heart attack

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

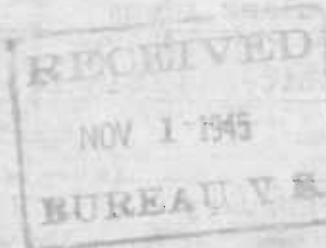
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edith B. Rawson M. D. or other:

Oakland, Maryland Date signed: 6-10-645

Address:



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

## CERTIFICATE OF DEATH

16131

Reg. Dist. No. 166

## 1. PLACE OF DEATH:

County Garrett

City or town Crellin, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Abigail Kendall Baker.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife John W. Baker.

Deceased

7. Birth date of deceased (mo., day, yr.) February 8, 1855

8. AGE: Years Months Days If less than one day  
90 7 2 4 hrs. min.

9. Birthplace Greenville Township, Penn.

(Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name John C. Kendall

13. Birthplace Greenville Township, Penn.

14. Maiden name Elizabeth Miller.

15. Birthplace Greenville Township, Penn.

16. Informant Mrs Homer Wright.

Address Crellin, Md.

17. Burial Date thereof October 8/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hostettler Cemetery

Location Meyersdale, Pa.

18. Funeral director George D. Borden

Address Lakeland, Md.

19. (Date rec'd by registrar) 19 A. Julian Rowan

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Grellin, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 2d 1945, 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

January 1945 to Oct 2nd 1945

and that I last saw her alive on 19.

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

Cerebral hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

McFarlinbaugh M. D. or other

Address Oakfield, Md. Date signed 10/45

RECORDED BY THE STATE ATTORNEY

FOR THE PEOPLE OF THE STATE OF ILLINOIS

RECORDED BY THE ATTORNEY GENERAL

RECORDED

NOV 1 1945

BUREAU V.R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

## CERTIFICATE OF DEATH

16132

Reg. Dist. No. 166

1. PLACE OF DEATH:  
 Garrett  
 County  
 Oakland  
 City or town  
 (If outside city or town limits, write RURAL and give nearest town)

New long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 On B & O Engine moving East from  
 Oakland, Md.

New long in hospital or institution?

## 3. (a) FULL NAME

Fred L. Cessna

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife:  
 Catherine Weaverling  
 Cessna

7. Birth date of deceased (mo., day, yr.) August 19, 1907

8. AGE: Years 38 Months 2 Days 8 If less than one day  
 . . . . . hrs. . . . . min.

9. Birthplace: Bedford Co., Pa.  
 (Town, county, and state)

10. Usual occupation: Breakman

11. Industry or business: B & O R. R.

12. Name: Thomas L. Cessna

13. Birthplace: Pa.

14. Maiden name: Jane Howsare

15. Birthplace: Pa.

16. Informant: Mrs. Catherine Cessna  
 Address: Cumberland, Md.

17. Burial: Rainsburg, Pa.  
 (Burial, cremation, or removal. Which?) Date thereof: Oct. 30, 1945  
 (month) (day) (year)

Cemetery or crematory: Bedford Co.

Location: Herbert L. Leightner  
 Address: Oakland, Md.

18. Funeral director: Herbert L. Leightner  
 Address: Oakland, Md.

19. (Date rec'd by registrar) 10/28/45

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Maryland County: Allegheny  
 City or town: Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R. D. Roberts Place  
 (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number  
 212-18-1330

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased item  
 and that I last saw him alive on 1945.

Immediate cause of death: Committed fracture (Fractured) Dura  
 Decapitated (Decapitated) Dura  
 Due to: Train Accident Dura

Due to: Dura

Other conditions: (Include pregnancy within 3 months of death)

Major findings or operations: Date of op.

Autopsy results: Date of 10/27/45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide: accident Date of 10/27/45

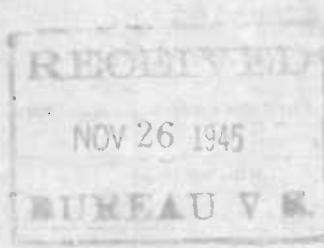
Where did injury occur: Oakland (City or town) Garrett (County) MD (State)

Injured at home, farm, industry, public place (where?) H. L. Cessna

Means of injury: Sharp steel agent Injured at work? Yes

Injury while on duty? Yes Injured at work? Yes

23. SIGNATURE: Herbert L. Leightner M. D. or other  
 Address: Oak Lee Md Date signed 10/28/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

73d

16133

## CERTIFICATE OF DEATH

Reg. Dist. No.

170

## 1. PLACE OF DEATH:

County..... Garrett

City or town..... Rural Near Avilton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Henry Steward Crowe

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Lavena Crowe

6.(c) If alive, give age..... 67 years  
7. Birth date of deceased (mo., day, yr.)..... March 11 1860

8. AGE: Years..... 85 Months..... 6 Days..... 28 If less than one day..... hrs..... min.....

9. Birthplace..... R.D.2 Grantsville Md  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business..... Farmer &amp; Timber Worker

12. Name..... Henry Crowe

13. Birthplace..... Not Known

14. Maiden name..... Harriet Durst

15. Birthplace..... Not Known

16. Informant..... Mrs Lavena Crowe

Address..... Avilton Md

17. Burial..... Date thereof..... 10-12-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... New Germany

Location..... R.D.2 Grantsville Md

18. Funeral director..... *John Schindler*

Address..... Grantsville Md

19. Oct 11 1945 Geo B Brown  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Garrett

City or town..... Rural Near Avilton  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 9 1945 at 7:00 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Oct 9 1945 and that I last saw h. m. alive on Oct 1 1945.

Immediate cause of death..... *Ischaemic Myocarditis 2 yrs* DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *W. R. Davis M.D.* M. D. or other

Address..... Grantsville Date signed Oct 11



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *1942*

19134

## CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH: **Garrett**  
 County .....  
 City or town **Rural Near Grantsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **Life**  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State **Md.** County **Garrett**  
 City or town **Rural Near Grantsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Kathryn May Durst**

## 3. (b) Social Security Number

4. Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced  
 .....  
 6.(b) Name of husband or wife **November 23, 1947** (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) **1945**  
 8. AGE: Years **10** Months **28** Days **0** If less than one day  
 ..... hrs. ..... min.

9. Birthplace **Rural Near Grantsville Md.**  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business  
 FATHER **Woodrow Durst**  
 12. Name .....  
 13. Birthplace **Rural Near Grantsville Md.**  
 MOTHER **Margaret Durst**  
 14. Maiden name .....  
 15. Birthplace **Rural Near Grantsville Md.**

16. Informant **Ritchard Durst**  
 Address **Grantsville Md.**

17. Burial **Burial** Date thereof **10-21-1945**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Durst**

Location **Rural Near Grantsville Md.**

18. Funeral director **Allen Winters**  
 Address **Grantsville Md.**

19. **Oct 20 1945 Ethel Broadwater**  
 (Date rec'd by registrar) **Registrar**

## MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct 19 1945**

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*Oct 11 1945* to *Oct 18 1945*  
 and that I last saw her alive on *Oct 15 1945*

Immediate cause of death

*Ehrnric Politis*

DURATION

*1mo*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE *H. R. Davis M.D.*

M. D. or other

Address *Grantsville* Date signed *Oct 22 1945*

REC

OCT 23 1945

BURBAD V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10135

## CERTIFICATE OF DEATH

Reg. Dist. No. 162

## 1. PLACE OF DEATH:

County ..... Garrett

City or town ..... On Rute 40 Near Grantsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Jacob Nelson Fasenbaker

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

July 23-1893

years

8. AGE:

Years  
52Months  
2Days  
26

If less than one day

hrs. min.

9. Birthplace ..... Rural Near Accident Md

(Town, county, and state)

10. Usual occupation ..... Laborer

11. Industry or business

12. Name ..... John T. Fasenbaker

13. Birthplace ..... Lonaconing Md Rural

14. Maiden name ..... Susan Durst

15. Birthplace ..... Rural Near Lonaconing Md

16. Informant ..... William Fasenbaker

Address ..... R. D. Accident Md

17. Burial ..... Date thereof ..... 10-23-1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory ..... Betheasda

Location ..... Rural Near Grantsville Md

18. Funeral director ..... Allen Whittlesey

Address ..... Grantsville Md

19. Oct 22 1945 - Ethel Madister  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md

County ..... Garrett

City or town ..... Rural N. Accident Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

220-10-2877

## MEDICAL CERTIFICATION

20. DATE OF DEATH

October 21

1945

at 12<sup>10</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Edw. W. Fasenbaker Jr. MD

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Crushing injuries to chest wall  
w/ R. shoulder, lungs

DURATION

Due to ..... Struck by car

Fracture of left tibia

Duo to ..... Fracture of left tibia  
multiple scalpel wound + hemorrhage

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results ..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Accident Date of 10/21/45

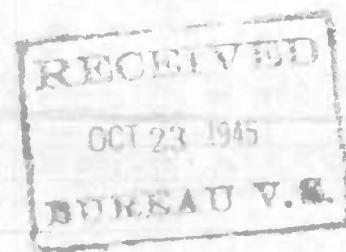
Where did injury occur? ..... Route 40 near Grantsville, Garrett Co. Md. (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ..... Public road

Means of injury ..... Street by car Injured at work? ..... No.

23. SIGNATURE: S. J. Baumgartner and Examiner Request  
M. D. or other Co.

Address ..... Darland, Md. Date signed 10/21/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

10136

## CERTIFICATE OF DEATH

166

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County ..... Garrett

City or town ..... Deer Park, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Franklin Henry Martin.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

B.(b) Name of husband or wife:.....

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 11th 1906

8. AGE: Years	Months	Days	If less than one day
39	7	16	..... hrs. ..... min.

9. Birthplace:.....  
(Town, county, and state) Somerset Pa.

10. Usual occupation:..... Farmer

11. Industry or business

12. Name:..... Daniel C. Martin.

13. Birthplace:..... Pennsylvania.

14. Maiden name:..... Charlotta Kraft.

15. Birthplace:..... Ohio.

18. Informant:..... Harry Martin.

Address:..... Somerset, Pa.

17. Burial Date thereof:..... Oct. 30th/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory:..... Somerset Cemetery.

Location:..... Somerset, Pa.

18. Funeral director:..... Murray D. Balder

Address:..... Oaklawn, Md.

19. (Date rec'd by registrar) 11/27/45 (Date) 1945 (Year)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State:..... Pennsylvania County:..... Somerset County

City or town:..... Somerset Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No:.....

(If rural, give LOCATION)

2.(a) If veteran, name war:.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1945 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Hannan after death 1945

and that I last saw h..... alive on 1945

Immediate cause of death:.....

Fracture of skull

Fracture right front fibula

Due to:..... Automobile + truck collision

Due to:.....

Other conditions:.....

(Include pregnancy within 8 months of death)

Major findings of operations:.....

Date of op. ....

Autopsy results:..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:..... accident Date of 10/27/45

Where did injury occur? ..... Deer Park (City or town) Garrett, Md. (County) (State)

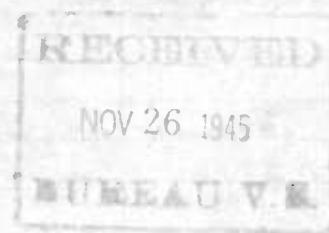
Injured at home, farm, industry, public place (where?) ..... Belmont Cemetary

Means of injury:..... Street by locomotive at work? No

Signature:..... John Benjamin, M.D., Elmer Davis, M.D.

M. D. or other:.....

Address:..... Oaklawn, Md. Date signed: 10/27/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 850

## CERTIFICATE OF DEATH

Reg. Dist. No. 161

16137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

MARGIN RESERVED FOR BINDING

I

## 1. PLACE OF DEATH:

County

Edgar

City or town

West Friendship

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Martha V Savage

4. Sex

F

5. Color or race

71

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

1863

years

8. AGE:

82

9

Months

30

Days

If less than one day

hrs.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Jessie Friend

FATHER

12. Name

Jessie Friend

13. Birthplace

Md

14. Maiden name

Friend

MOTHER

15. Birthplace

Md

16. Informant

Metropolitan Savage

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

11/4/45

(month) (day) (year)

Cemetery or crematory

Sandefjord

Location

Sandefjord

18. Funeral director

Metropolitan Savage

Address

Friendship

19. (Date rec'd by registrar)

11/6/45

19

45

for P. Bush

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

October 31 - 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct - 24 - 1945, fe

and that I last saw her alive on Oct - 24 - 1945.

Immediate cause of death

Hemiplegia

DURATION

1

Due to

Cerebral hemorrhage

9

Due to

1

Other conditions

9

(Include pregnancy within 3 months of death)

Major findings at operations

1

Date of op.

1

Autopsy results

1

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Date of

Where did injury occur? (City or town) (County) (State)

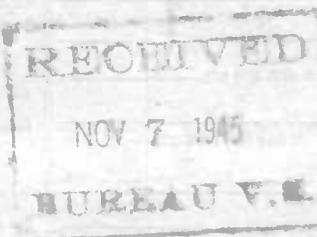
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H. B. Munroe (Mo) M. D. (or other)

Address Addison - 124 Date signed 11/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 924

10138  
866

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Garrett County  
County.....

City or town..... Hutton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Levenia Ellen Scott.

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.

6. (b) Name of husband or wife..... Birt C. Scott.

7. Birth date of deceased (mo., day, yr.) April 29th, 1874. 6. (c) If alive, give age 71 years

8. AGE: 

Years	Months	Days	If less than one day	
71	5	20	hrs.	min.

9. Birthplace..... Garrett County, Md.  
(Town, county, and state)

10. Usual occupation..... House wife.

11. Industry or business

FATHER 12. Name..... Edward Wolfe.

MOTHER 13. Birthplace..... Preston County, W. Va.

14. Maiden name..... Annabelle Glover.

15. Birthplace..... Preston County, W. Va.

MOTHER 16. Name..... Birt C. Scott.

17. Informant.....

Address..... Hutton, Md.

Burial 18. Burial (Burial, cremation, or removal? Which?) Date thereof..... October 21/45

Cemetery or crematory..... Oakland Cemetery.

Location..... Oakland, Md.

19. Funeral director..... Harold P. Miller.

Address..... Oakland, Md.

Date rec'd by registrar..... Oct 20 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Garrett

City or town..... Hutton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 18th 1945 at 7:30p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on  
June 23 1945 to 1945

and that I last saw her alive on 6/23/45

Immediate cause of death Cardiac

decompensation —

Due to Pneumonia and Moderate Impression

Due to Moderate osteoarthritis

Other conditions Moderate osteoarthritis

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Harold P. Miller M. D. or other

Date signed 10/24/45

Address..... Eaton, W. Va.

RECEIVED

NOV 26 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

10139

Reg. Dist. No. 166

1. PLACE OF DEATH: Garrett  
 County ..... Garrett  
 City or town ..... Oakland, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life time  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State ..... Maryland ..... County ..... Garrett  
 City or town ..... Oakland, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

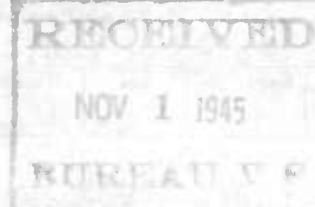
3. (a) FULL NAME  
 John G. D. Spiker.  
 4. Sex ..... Male ..... 5. Color or race ..... White ..... 6.(a) Single, married, widowed, or divorced ..... Married.  
 6.(b) Name of husband or wife ..... Mary Tucker Spiker  
 7. Birth date of deceased (mo., day, yr.) ..... September 22d, 1862  
 8. AGE: Years ..... 83 Months ..... 0 Days ..... 15 If less than one day ..... hrs. ..... min.  
 9. Birthplace ..... Garrett County. (Town, county, and state)  
 10. Usual occupation ..... Retired Farmer.  
 11. Industry or business  
 12. Name ..... Abraham Spiker.  
 13. Birthplace ..... Garrett County.  
 14. Maiden name ..... Sarah Jane Riley.  
 15. Birthplace ..... Garrett County.  
 16. Informant ..... Mrs. Mary Spiker.  
 Address ..... Oakland, Md.  
 17. Burial ..... Date thereof Oct. 10/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory ..... Oakland Cemetery.  
 Location ..... Oakland, Maryland.  
 18. Funeral director ..... Eunice D. Holden.  
 Address ..... Oakland, Md.  
 19. (Date rec'd by registrar) ..... 10/9/45 ..... 1945 ..... Date of death ..... 10/9/45  
 Registrar

3. (b) Social Security Number ..... None  
 MEDICAL CERTIFICATION  
 2D. DATE OF DEATH ..... October 8th ..... 1945 ..... a6:00A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... August 1944 ..... to ..... October 1945 ..... and that I last saw him alive on ..... October 7 ..... 1945 .....  
 Immediate cause of death ..... Chronic Myocardiitis .....  
 Due to ..... Arteriosclerosis ..... Pneumonia ..... Myopathology .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 8 months of death)  
 Major findings of operations ..... Date of op. ....  
 Autopsy results ..... none .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) ..... (County) ..... (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....  
 23. SIGNATURE ..... 801 Baumgartner Rd. ..... M. D. or other .....  
 Address ..... Oakland, Md. ..... Date signed ..... 10/9/45

MEMORANDUM FOR THE CHIEF STATE CHAIRMEN

LETTERS TO STATE CHAIRMEN



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 350

## CERTIFICATE OF DEATH

16140 166  
Reg. Dist. No.

1. PLACE OF DEATH:  
Garrett  
County.....

City or town..... Oakland, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Miss Marian Roberta White

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 9th, 1871

8. AGE:	Years	Months	Days	If less than one day
	74	9	2	.....hrs. .....min.

9. Birthplace..... Garrett County, Md.  
(Town, county, and state)

10. Usual occupation..... Retired Dress Maker.

11. Industry or business..... Rowan White.

MOTHER FATHER  
12. Name..... Garrett County, Md.

13. Birthplace..... Margaret Waltz.

14. Maiden name..... Garrett County, Md.

15. Birthplace..... Mrs. Margaret Rodeheaver.

16. Informant..... Address Oakland, Md.

17. Burial..... Date thereof. Oct 15th/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oakland Cemetery.

Location..... Oakland, Md.

18. Funeral director..... Address Edward E. B. Rodeheaver  
Oakland, Md.

19. (Date rec'd by registrar) 10/14/45 19..... Julie Rowan  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Garrett  
City or town..... Oakland, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11th, 1945 8:30P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from  
7-7-44 10-11-45 and that I last saw her alive on 10-10-45

Immediate cause of death..... Cerebral Hemorrhage DURATION 2 days

Due to.....

Due to.....

Other conditions..... Arthritis Deformans DURATION 6 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

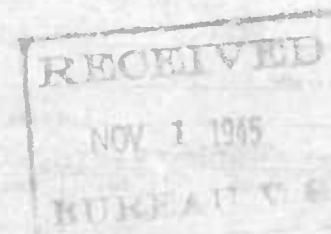
Means of injury..... Injured at work?

23. SIGNATURE..... Edward E. B. R. 10/11/45  
Oakland, Maryland M. D. or other

Address..... Date signed..... 10-11-45

LETTERS TO THE STATE CHAMBERS

LETTERS TO THE STATE CHAMBERS



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 730

16141

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

## 1. PLACE OF DEATH:

County Garrett

City or town Oakland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Almeda Catherine Yost.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife John C. Yost

Deceased

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11th, 1859

8. AGE: Years Months Days If less than one day  
86 10 3 hrs. min.

9. Birthplace Cranesville, W. Va.

(Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name John G. Sines.

13. Birthplace Cranesville, W. Va.

14. Maiden name Lucinda Wilhelm.

15. Birthplace Cranesville, W. Va.

16. Informant Miss May Yost.

Address Oakland, Md.

17. Burial Date thereof Oct 10th/45  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Ashby Cemetery.

Location Near Crellin, Md.

18. Funeral director Murray A. Bolden

Address Oakland, Md.

19. (Date rec'd by registrar) 1945

Julia Rowan Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Oakland, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 7th 1945 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 4th to October 1945

and that I last saw her alive on October 5 1945

## Immediate cause of death

Chronic Myocarditis

DURATION

## Due to

Acute Tonsillitis

Due to Chronic Myocarditis

DURATION

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address Oakland, Md. Date signed 10/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

